to make payment" with respect to an item or service covered under Medicare. 42 U.S.C. 1395y(b)(2)(B)(iii) (emphasis added).

Congress thus expressly provided that "an employer that sponsors or contributes to a group health plan" may be required to reimburse Medicare, regardless of whether the employer's responsibility for the plan's payments is felt "directly" or "otherwise," and regardless of whether the employer was "required" itself to make the payment in the normal course of business. 42 U.S.C. 1395y(b)(2)(B)(iii). With those amendments, Congress ratified the agency's preexisting regulation that imposes liability on an employer that sponsors or contributes to an employee group health plan, without regard to whether the plan was self-insured or underwritten by a third-party insurer. 42 C.F.R. 411.24(e) (explaining that the United States has a direct right of action against, *inter alia*, "an employer," "an insurance carrier," and "a third party administrator," without regard to whether the entity was contractually or directly required to pay for the cost of medical care); see also C.A. App. 34.

There is no dispute that petitioner sponsored and contributed to an employee group health plan. And as discussed above (at 3), even where an employer such as petitioner has, by contract, shifted to an insurance company the responsibility for paying the claims for services to those individuals covered by a group health plan, the employer sponsoring or contributing to the plan remains responsible for payment being made in a manner that comports with the requirements of the MSP statute. See also Pet. App. 15a-16a. Accordingly, under the plain terms of 42 U.S.C. 1395y(b)(2)(B)(iii), petitioner is required to reimburse the Medicare program if Medicare

makes a payment for an item or service also covered under petitioner's employee group health plan.

As the court of appeals explained (Pet. App. 13a-14a), petitioner's contention (Pet. 12-13) that only self-insured employers may be required to reimburse Medicare would make the provision's separate reference to "self-insured" entities superfluous. In an attempt to give meaning to the phrase "an employer that sponsors or contributes to a group health plan," petitioner argues (Pet. 13) that Congress intended the phrase to refer to "self-insuring nonprofit or charitable" employers since self-insurers are limited to only for-profit business. The statute says nothing of the sort. The statute merely "deem[s]" an entity engaged in a business, trade, or profession (without specifying whether they operate for profit or not for profit) to be self-insured when it carries its own risk; the statute does not bar charitable organizations (or for that matter any other entity) from becoming a self-insurer, or otherwise provide a limiting definition for a self-insurer. 42 U.S.C. 1395y(b)(2)(A). In any event, had Congress wanted simply to impose liability on a separate category of "non-profit self-insurers," it could have easily done so and would not have used the quite different phrase "an employer that sponsors or contributes to a group health plan." 42 U.S.C. 1395y(b)(2)(B)(iii).

Petitioner and its amici advance a variety of policy objections to the 2003 amendments, suggesting that they impose new costs on employers that sponsor or contribute to employee group health plans. But the objections misunderstand the statutory scheme. Although petitioner and its amici focus on perceived harm to small employers, the plans of small employers are exempt from the statute's requirements. 42 U.S.C.

1395y(b)(1)(A)(ii). Moreover, even for employers that are covered, an employer is always free to arrange by contract to have its third-party insurer reimburse Medicare directly and thus satisfy the employer's obligation to Medicare. Likewise, an employer is free to negotiate with its third-party insurer for an indemnity for any MSP liability. What the employer may not do, as the 2003 amendments confirm, is relieve itself by contract with a third-party insurer of any responsibility to reimburse the Medicare program when Medicare makes payment for items or services also covered under the employer's group health plan.

2. The panel's decision does not conflict with a decision from any other court of appeals. Indeed, no other court of appeals has addressed the provision of the 2003 amendments at issue in this case. All of the court of appeals decisions that petitioner cites (Pet. 9-10) were decided before Congress enacted the 2003 amendments. Moreover, none of those cases addressed the question presented here: whether an employer that sponsors or contributes to an employee group health plan by purchasing third-party insurance may be required to reimburse Medicare. In *United States* v. *Baxter Int'l, Inc.*, 345 F.3d 866 (2003), cert. denied, 542 U.S. 946 (2004), the Eleventh Circuit sustained the government's right under the MSP statute to seek reimbursement from the manufacturers of breast implants that had settled mass tort litigation. In *Mason* v. *American Tobacco Co.*, 346 F.3d 36 (2003), cert. denied, 541 U.S. 1057 (2004), the Second Circuit rejected an attempt by private individuals to sue tobacco manufacturers under the MSP statute. In *Health Ins. Ass'n of America, Inc.* v. *Shalala*, 23 F.3d 412 (1994), cert. denied, 513 U.S. 1147 (1995), the D.C. Circuit held that the government could not recover from

an insurer acting solely as the third-party administrator of an employer group health plan. That decision, however, was overridden by Congress. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4633(a), 111 Stat. 487. And *Waters* v. *Farmers Texas County Mut. Ins. Co.*, 9 F.3d 397 (5th Cir. 1993), concerned the amount that the government was entitled to recover from the proceeds of an automobile insurance policy. The only decision that does support petitioner's position is an unpublished district court decision, *Manning* v. *Utilities Mut. Ins. Co.*, No. 98 Civ. 4790(RCC), 2004 WL 235256, at *6 (S.D.N.Y. Feb. 9, 2004). The government was, moreover, not a party in that case, and the court did not discuss the 2003 amendments to the MSP statute.

Petitioner's amici suggest (Br. 16) that it would be futile to await a conflict on the issue presented here because they believe that the issue inevitably will arise in the Federal Circuit. Petitioner similarly argues (Pet. 18) that any challenge to the government's imposition of MSP liability on employers must arise in the Federal Circuit because the government may impose liability by administrative offset against those employers who may be entitled to tax refunds under 31 U.S.C. 3720A. Those arguments lack merit, and MSP cases routinely arise outside the Federal Circuit, as the cases discussed above illustrate. This case arose in the Federal Circuit because petitioner chose to make payment to Medicare under protest and then sue for a refund, see Pet. App. 3a, 5a. Moreover, in any case where offset is unavailable (*i.e.*, because the employer is not entitled to receive money from the Treasury), the government would have to sue in the federal district court where the employer resides. 28 U.S.C. 1391(b).

Moreover, the issue of whether employers such as petitioner are liable may arise in cases where the government is not a party. The MSP statute creates a private cause of action against any primary plan (such as the group health plan sponsored by petitioner, see 42 U.S.C. 1395y(b)(2)(A), that refuses to make primary payment). 42 U.S.C. 1395y(b)(3)(A). The only other case to address the precise issue presented here arose in the Southern District of New York when a beneficiary argued that an employer such as petitioner was responsible for making payment under a primary plan. See *Manning*, 2004 WL 235256, at *6. There is therefore no reason to think that if the issue is important and recurring it will not arise in other courts of appeals.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted.

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Supreme Court of the United States

TELECARE CORP.,

Petitioner,

v.

MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND CENTER FOR MEDICARE AND MEDICAID SERVICES,

Respondents.

On Petition For A Writ Of Certiorari To The Court Of Appeals For The Federal Circuit

BRIEF *AMICI CURIAE* OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND NATIONAL FEDERATION OF INDEPENDENT BUSINESS LEGAL FOUNDATION IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

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INTEREST OF *AMICI CURIAE*[1]

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation representing an underlying membership of nearly three million businesses, state and local chambers of commerce, and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of the national business community by filing *amicus curiae* briefs in cases involving issues of concern to American business.

The National Federation of Independent Business Legal Foundation ("NFIB Legal Foundation"), a nonprofit, public interest law firm established to protect the rights of America's small-business owners, is the legal arm of the National Federation of Independent Business (NFIB). NFIB is the nation's oldest and largest organization dedicated to representing the interests of small-business owners throughout all 50 states. The approximately 600,000 members of NFIB own a wide variety of America's independent businesses from restaurants to manufacturing firms to bowling alleys.

The membership of the Chamber and NFIB has an interest in this case because many of them maintain medical benefit plans covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). They are vitally interested in preserving the

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[1] Pursuant to Sup. Ct. Rule 37.6, *amici* represent that counsel for a party did not author this brief in whole or in part, and no person or entity other than the *amici*, their members and their counsel made a monetary contribution to the preparation or submission of this brief.

freedom afforded them under ERISA to cap their exposure to liability under such plans by purchasing insurance. In addition, the Chamber and NFIB wish to bring to the Court's attention an important fact that may have been overlooked in the court below but that unlocks the statutory provision at issue.

Both petitioner and respondents have consented to the filing of this brief. The parties' letters of consent are being filed simultaneously with this brief.

STATEMENT OF THE CASE

Petitioner maintains an employee welfare benefit plan under ERISA that consists of purchasing medical insurance for its eligible employees. The benefit promised by the plan is the payment of premiums on the medical insurance; petitioner has no liability under terms of the plan to reimburse employees for medical expenses.

A beneficiary under petitioner's plan incurred an expense for which the beneficiary was entitled to reimbursement under the plan from the insurance company. Instead, Medicare paid the expense by mistake. Respondents, including the administrator of the Medicare program, sought reimbursement from petitioner, relying on the Medicare Secondary Payer program, codified at 42 U.S.C. § 1395y(b)(2), which requires reimbursement by "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan."

Having no success at convincing respondents that petitioner was not an entity that was required or responsible

to make payment under petitioner's plan, petitioner paid and sued respondents for a refund. The United States District Court for the Northern District of California dismissed the complaint. The U.S. Court of Appeals for the Federal Circuit affirmed (409 F.3d 1345), holding that all employers who maintain insured medical plans are *ipso facto* "responsible" for reimbursements under such plans and therefore liable to reimburse Medicare for any mistaken payments made by Medicare.[3]

REASONS FOR GRANTING THE WRIT

The Federal Circuit framed the question as "either/or": either all employers with insured medical plans are exposed to liability under Medicare Secondary Payer or none are. Concluding that neither alternative exactly squared with the statutory language, it chose what it perceived as the lesser of two evils.

What the decision below overlooked is the fact that some employers with insured medical plans still bear ultimate financial liability for the benefits (notwithstanding the insurance), while other employers with insured medical plans promise only to pay insurance premiums, not to provide the ultimate medical benefits. The latter approach is not only permitted by ERISA but vital to

[3] Specifically, the Federal Circuit held that "responsible" under the statute includes any "degree of accountability," and all employers who sponsor or contribute to medical insurance plans have a "degree of accountability." App. at 16a. The Federal Circuit made no effort to explain the source or nature of this "degree of accountability" in the face of petitioner's allegation, which the court accepted as true, that petitioner bore no financial responsibility to employees under its plan beyond the payment of premiums on medical insurance, and thus had no liability to reimburse employees for eligible medical expenses.

enable small businesses to cap their exposure at the premium paid.

With that understanding, a more nuanced view of the statute is possible and suddenly the language of the statute makes perfect sense: employers with insured medical plans who bear ultimate financial liability for the benefits may be liable under Medicare Secondary Payer (just as they would have been liable for the benefits if no mistake had been made), whereas employers who have limited their commitment to paying premiums (and thus would not have been liable for the benefits even if no mistake had been made) are not liable under Medicare Secondary Payer.

It is important that the Court correct this error for two reasons. First, the decision below effectively strips small businesses of the ability to protect themselves against catastrophic medical expenses through purchasing insurance and can only accelerate the trend toward elimination of medical insurance benefits among small business, contrary to public policy. Second, because of the self-help available to the government to enforce the error and because of the exclusive jurisdiction of the Federal Circuit, this Court's review may represent the only effective remedy.

A. In An Insured Medical Plan, ERISA Leaves The Employer Free To Take Ultimate Financial Responsibility For The Benefits Or Not, As the Employer Chooses.

In ERISA, Congress left employers free to define the promise that they make to employees in their employee benefit plans, focusing instead on assuring that the promise is kept. As this Court stated just last term in *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004):

> There is no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promise them.
>
> "Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan. ERISA does, however, seek to ensure that employees will not be left empty-handed once employers have guaranteed them certain benefits. . . . [W]hen Congress enacted ERISA, it 'wanted to . . . mak[e] sure that if a worker has been promised a defined pension benefit upon retirement – and if he has fulfilled whatever conditions are required to obtain a vested benefit – he actually will receive it.'"

This is all the more true in the case of welfare benefit plans such as medical insurance plans.[3] In *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995), this Court reiterated:

> [W]e are mindful that ERISA does not create any substantive entitlement to employer provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.

Introducing the subject of welfare benefit plans, the authoritative treatise *Employee Benefits Law*, edited by the Employee Benefits Committee of the Section of Labor

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[3] ERISA divides the universe of employee benefit plans into those which provide retirement income ("employee pension benefit plans") and those which provide other health and welfare benefits ("employee welfare benefit plans").

and Employment Law of the American Bar Association and published by The Bureau of National Affairs, Inc., sets the stage succinctly:

> Although Congress stated, when it enacted ERISA in 1974, its intent to occupy the field of regulating health, life insurance and a broad array of other nonpension benefits, and subjected state laws attempting to regulate such benefits to ERISA's broad preemption clause, ERISA subjected welfare benefit plans to virtually no substantive regulation other than the reporting and disclosure and fiduciary duty rules. Since 1974, Congress has not added to ERISA any substantive requirements on the nature or content of welfare plans other than the "continuation coverage" rules.

Id. at 944 (1991). Thus, with regard to welfare plans, Congress has left the employer free to define the particulars of any promise that it may choose to make to the employees in the plan document.[4]

When it comes to medical plans, the employer's freedom to define the promise that it makes to its employees offers two principal possibilities: (1) the employer may promise that employees will receive reimbursement for specified medical expenses or (2) the employer may promise to pay premiums to purchase medical insurance that provides reimbursement for specified medical expenses. The former is a promise of what the employee will get *out*

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[4] In this regard, welfare plans stand in contrast to pension plans. In ERISA, Congress chose to regulate pension plans with detailed substantive standards regarding, among other things, eligibility to participate in the plan, accrual of benefits ratably over time, vesting, funding, and the form and time of payment of benefits. In ERISA, Congress chose not to regulate the substance of welfare plans in the same way. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

of the plan (a form of defined benefit), whereas the latter is a promise of what the employer will put *into* the plan (a form of defined contribution), and there is a vast legal difference between those two approaches with respect to the employer's responsibility.

1. If the employer promises that employees shall receive reimbursement for specified medical expenses, the employer bears the ultimate responsibility for satisfying those expenses. The employer may fulfill that promise by reimbursing employees out of its general assets upon presentation of claims. That is the classic "self-funded" arrangement.

Alternatively, the same employer might adopt a funding mechanism such as purchasing a group medical insurance policy or establishing a trust as a matter of prudent financial planning to assure that its promise will be fulfilled.[5] The important point is that in either of those arrangements – insurance or trust – the plan still provides that the employer bears the ultimate financial responsibility for the benefits.

Such plans are most commonly found in the collective bargaining context, where the employer has entered into a collectively bargained insurance agreement that commits the employer to the bottom-line result but leaves the employer free to produce that result by insuring, self-insuring, or any other method. *See, e.g., Diehl v. Twin Disc, Inc.*, 102 F.3d 301, 310 (7th Cir. 1996) ("Rather, the Insurance Agreement obligated Twin Disc to secure a certain level of benefits, and Twin Disc presumably remained free

[5] Such a trust is the VEBA trust, technically known under the Internal Revenue Code as a voluntary employees' beneficiary association. 26 U.S.C. § 501(c)(9).

to negotiate with various insurance carriers (or to self-insure) and to impose cost-saving measures that did not substantially reduce benefits"), and *Senn v. United Dominion Industries, Inc.*, 951 F.2d 806, 810 (7th Cir. 1992) (where the collectively bargained insurance agreement provided, "The Company reserves the right to select or change the insurance carrier(s) or to self fund the negotiated group benefits"). *Cf.* the myriad of cases testing whether the employer violated the collectively bargained insurance agreement by selecting a different insurance carrier, such as *UAW v. Mack Trucks, Inc.*, 917 F.2d 107 (3d. Cir. 1990), *cert. denied*, 499 U.S. 921 (1991).

2. On the other hand, the employer may promise no more than to pay premiums to purchase medical insurance covering its employees. It is up to the employer to define the promise that it makes to the employee, after all, and many smaller employers choose to limit their promise to paying insurance premiums. In such an arrangement, the employer has not promised that the employee will receive reimbursement for certain medical expenses, only that the employee will receive paid-up insurance coverage. The nature of the promise, as set forth in the plan document, is the key.

This understanding springs from the core proposition that ERISA does not regulate the content of the promise. Because ERISA does not regulate the content of the promise, ERISA leaves an employer entirely free to limit its promise to paying premiums on insurance. If the plan document appropriately limits the employer's promise to payment of premiums, then the benefit provided by the plan is the payment of insurance premiums. As soon as the employer pays the premium, it has provided the full